Children's Medical Services Network

Utilization Management Provider Handbook

Thank you for participating as a Children's Medical Services (CMS) Network provider. This Utilization Management Provider Handbook is a guide to the policies and procedures for the Service Authorization Utilization Management Process.

Prior authorization is a condition of reimbursement for identified services included in this handbook. Payment is contingent upon receipt of prior authorization for identified services and members must be eligible on the date the service is provided. Prior authorization for these services may be requested by the member's primary care provider, a treating specialist, or a treating facility.

The Early Steps program authorizes services through the Individualized Family Support Plan (IFSP) process. Services for this program are excluded from this handbook. Please contact your local Early Steps provider with any questions.

A copy of this handbook can be found at http://www.cms-kids.com/providers/providers.html**.**
Please refer to this site regularly to ensure you are accessing the most updated copy of this document.

CMS has partnered with **Ped-I-Care** and **South Florida Community Care Network (SFCCN)** to authorize the services described in this handbook when provided to **CMS Title XXI (Florida KidCare)** enrollees. These partners will make the determination to provide a service based on review of submitted information and a determination of medical necessity. **Ped-I-Care** and **SFCCN** each support CMS in different areas of the state. **Please see the child's member ID card to know which entity will review your requests.**

Service authorizations for children enrolled in the **CMS Safety Net** program are the responsibility of the **CMS area offices.**

Providers may also call **1-800-664-0146** or email **FI-CustomerService@Med3000.com** with any questions or concerns regarding **claims payment** of authorized services.

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Children's Medical Services

Table of Contents

Section 1.0. Covered Services Requiring Prior Authorization

1.0.1. Services Requiring Referrals and Authorizations for CMS Title XXI (Florida KidCare)

- The following list includes those services that require a referral or prior authorization for children enrolled in CMS Title XXI (Florida KidCare).
- If unsure whether a specific procedure/service/facility requires an authorization, contact the utilization management department listed on the child's member ID card.
- For the services listed below, an authorization number will be assigned for the requested service and must be on the claim for payment.

Services Requiring Referral or Authorization
Referrals
PCP to Specialist Referrals
Specialist to Specialist Referrals
[1] **Prior Authorization – *supporting clinical documentation is required***
Applied Behavioral Analysis (Therapy)
By Report Special Procedures
Colonoscopy and Endoscopy
Durable Medical Equipment (all items including insulin pumps, custom wheelchairs, and scooters)
Elective Surgical Procedures (including cosmetic and plastic/reconstructive procedures per Medicaid Physician Fee Schedule)
Global Obstetrical Office Visits/Ultrasounds
Hearing Services / Hearing Aids / Augmentative or Alternative Communicative Systems
Home Health Services
Hospice/Palliative Care (including Partners In Care:Together For Kids)
Inpatient Hospitalization (including mental health and skilled nursing facilities)
Mental Health Day Treatment Programs
MRI, CT's, PET scans

Nutritional Supplements / Enteral & Parenteral Nutrition
Observation Stays
Oral Surgery
Orthotics and Prosthetics
Orthodontia
Out of Network /Out of State Services- every service, including services that generally do not require authorization
Private Duty Nursing / PPEC
Therapy Services (PT, OT, Speech and Respiratory)
Transplants and Related Care
Vision Services (Contact Lenses Specialty (non-standard) Glasses)
Notification Required – services does not require prior authorization just notification that the service was rendered for coordination of care purposes only
Emergency Room Visit - Notification Only
Hospital Admission from an Emergency Room Visit – Notification Only

[1] Prior authorization requests require the provider submit supporting clinical documentation for medical review. Failure to provide clinical information can result in a delay or denial of the request.

1.0.2. Authorization of Services for CMS Title XXI (Florida KidCare) Not Listed Above

- Authorization is required when the requested service meets any of the following conditions
  - is not a covered benefit,
  - exceeds Medicaid covered allowable limits, or
  - is to be provided by an out of network or out of state provider.

- CMS may pay for services that are not a covered benefit or are beyond the Medicaid allowable limits, based on determination of medical necessity. Providers must submit detailed medical documentation supporting the need and benefit of these services. Please use the form in Appendix I to submit these special exception requests.

- CMS does not pay for experimental procedures.

- If approved, an authorization number will be assigned for the requested service and must be on the claim for payment.

1.0.3. Authorization for Services to Children Enrolled in the CMS Safety Net Program

- Children enrolled in the CMS Safety Net program are only eligible for a limited selection of services.

- Every service must be prior authorized for children enrolled in the Safety Net program.

- Each child can be authorized to receive care for a primary and secondary qualifying condition. If a child has more than two qualifying conditions, the family determines which conditions will be covered under the CMS Safety Net program.

- Eligible services include
  - specialty physician services to treat the qualifying conditions,
  - diagnostic services need to treat the qualifying conditions,
  - pharmacy services needed to treat the qualifying conditions, and
  - dental services only for children with a cleft lip/cleft palate diagnosis.

- Primary care, durable medical equipment, emergency room, and inpatient hospital care are not covered services for this program.

- Each family must meet a sliding-fee participation requirement before CMS can be authorized to pay for any service.

- If you are unsure if a service can be provided under this program, please contact your local CMS office.

Section 2.0. Process for Requesting Prior Authorization

2.0.1. Submitting Prior Authorization Requests

- You may submit prior authorization requests through the **CMS-KIDS Web portal at: https://cms.einfosource.med3000.com or by contacting the UM department listed on the child's member ID card.**

- For services that are special exceptions (outside the Medicaid benefit package or over Medicaid coverage limits), please use the special exception form in Appendix I.

    - The local CMS area office may only submit prior authorization requests on behalf of providers who provide clinic services or who otherwise do not have a stand-alone office and support staff.

- For children enrolled in the CMS Safety Net program, if submitting the authorization by fax, please contact the intended recipient of the request prior to faxing to ensure availability of staff to receive the information.

- Each request must include a signed physician order and supporting documentation. The physician order must specify the units of service, hours per day, or time period for which authorization is being requested. Requests for services that lack sufficient information or documentation to make a determination may be closed if the requested information is not supplied within five (5) business days.

- A new request must be submitted for any continuation of services beyond the initial authorized time period. These requests may be submitted up to 60 days prior to the expiration of the current authorization.

- If an expedited request is needed after normal business hours the provider should process the request following the urgent and emergency processes outlined in section 2.0.2. below.

- CMS will not be responsible for payment of services requiring authorization that have not been prior approved or rendered outside the authorization date span.

- An authorization number will be assigned for the requested service and required on the claim for payment.

2.0.2. Response Time for Prior Authorization Requests

- Routine Request
  A determination will be made for all non-urgent requests for authorization within fourteen (14) calendar days of obtaining all necessary information. Providers will be notified of approval or denial within one (1) calendar day of making the decision.

- Urgent Request
  A determination will be made for all urgent care requests within seventy-two (72) hours of receiving all necessary information. Upon determination the requesting provider will be notified by telephone immediately with a letter to follow.

- Emergent Request
  A determination will be made for all emergent care requests within twenty-four (24) hours of receiving all necessary information. Upon determination the requesting provider will be notified by telephone immediately with a letter to follow.

2.0.3. Appeal Process for Denied, Reduced, Suspended, or Termination of Services

- When an authorization request is denied the enrollee or provider has the right to appeal the decision.

- An appeal may be filed orally or in writing within ninety (90) calendar days of the date of the notice of action and, except when an expedited resolution is required, must be followed with a written notice within ten (10) calendar days of any oral filing. The initial date of receipt of either an oral or written appeal shall constitute the date of receipt.

- The following information will be required for each appeal
  - enrollee's full name and date of birth,
  - enrollee's individual identification number,
  - complainant's name, if not the enrollee,
  - name of provider who ordered the health service,
  - name of provider requesting the appeal, if applicable,
  - type of action in dispute (e.g., delay, denial, reduction, suspension or termination),
  - duration and frequency of the disputed health service, if applicable,
  - medical necessity of the health service to include additional documentation as needed to support the request,
  - if the provider is out of network, documentation to substantiate that the health service cannot be performed by a CMS Network provider,
  - a copy of the original notice of action in dispute, and
  - if a continuation of disputed health services is being requested.

2.0.4. Appeal Process for Failure to Approve, Furnish, or Provide Payment for Health Services

- An explanation of all claims submitted from providers will be documented on the Explanation of Benefits (EOB) sent to the provider. Each claim submitted is noted as paid or will include an explanation of the reason for non-payment.

- If the provider believes there has been an error in the payment denial or has any questions about the interpretation of or disagrees with the adjudication, the provider should first attempt to resolve the issue through the fiscal agent's customer service at 1-800-664-0146 or by email at FI-CustomerService@Med3000.com.

- If unsuccessful with this first level appeal, the provider should contact Ped-I-Care or SFCCN as identified on the member ID card.

- **Please see the member's ID card** for assistance or to request information on submitting a written formal appeal.

- If a provider submits an appeal, Ped-I-Care or SFCCN will provide a written response within 45 days of receipt of the appeal.

- Examples of reasons for payment denial for actively enrolled members include but are not limited to
    - no prior authorization where one was required,
    - incorrect enrollee information,
    - use of out of network provider without prior authorization,
    - no primary care provider referral,
    - incomplete claims information, or
    - insurance paid the maximum allowable for the service or the benefit limits have been met.

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Section 3.0. Summary for Selected Services for Referral, Authorization, and Notification

Referrals

3.0.1. Primary Care to Specialist and Specialist to Specialist Referrals

- The member's primary care provider must obtain a referral authorization for all specialist services. Specialists must also obtain a referral authorization for all referrals to other specialists.
- Submitting these requests generates an automatic response with a referral authorization number.
- CMS care coordinators will use this referral authorization process to better assist families in scheduling appointments and ensuring that the family attends needed appointments.

Authorization

3.0.2. Applied Behavior Analysis

- Prior authorization is required for Applied Behavior Analysis services necessary for the treatment of autism spectrum disorders.
- Treating providers must meet Medicaid qualifications and may submit a prior authorization request for medically necessary services for a child diagnosed with any of the following ICD-9 diagnosis codes: 299, 299, 299.00, 299.01, 299.10, 299.11, 299.8, 299.80, 299.81, 299.9, 299.90, or 299.91.
- Contact the utilization management department listed on the child's member ID card for provider requirements and covered services. Or refer to the July 6, 2012, Medicaid Coverage and Prior Authorization of ABA for Children under 21 with Autism Provider Alert at this location http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_ProviderAlerts/tabId/43/Default.aspx

3.0.3. By Report Special Procedures

- By report procedures require documentation of medical necessity for the procedure performed or information is needed in order to review and price the procedure correctly. This requires a written report to be submitted with the claim.
- Please see the Medicaid Practitioner Services Coverage and Limitations Handbook, December 2012, Section 3 for more detailed information. http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_12_12-12-01_Practitioner_Services_Handbook.pdf

3.0.4. Durable Medical Equipment

- Prior authorization is required and must include a signed written order by the treating physician/PA/ARNP or treating podiatrist. See Medicaid DME and Medical Supply Services Coverage and Limitation Handbook. http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_10_100601_DME_ver1_0.pdf

- For children receiving on-going DME who require renewals, the ordering physician or primary care provider must evaluate the member face-to-face at a minimum of every six (6) months.

- Services will not be reauthorized without documentation of a physician face-to-face evaluation.

3.0.5. Elective Surgical Procedures - Hospitalization

- Prior authorization is required for all elective hospitalizations.

- Any post-discharge services requiring authorization must be communicated through the normal authorization process described above.

- The CMS Safety Net program is a limited service package and does not cover inpatient hospital care services.

3.0.6. Home Health Services

- A request for home health services is generally made in two phases: the initial assessment and the treatment plan.
    - The primary care or specialty physician will submit a prior authorization request for the initial assessment.
    - If approved, the home health agency will conduct the assessment and develop a proposed treatment plan.
    - Once the treatment plan is approved and signed by the requesting provider, the plan must be submitted for authorization of services.

- Initial requests for home health care will be authorized for no more than a 60-day duration to allow for any reevaluation.

- Continuing private home health care services will be authorized for no more than a six (6) month duration and will require a medical consultation by the ordering or attending physician.

- During the approval period, if there is a change in the member's status or a change in hours necessary to care for the member, a new request for authorization must be submitted along with documentation of the changes in the member's condition that necessitates the requested change.

3.0.7. Hospice/Palliative Care Services (PIC:TFK)

- The primary care provider is required to obtain prior authorization for routine requests for hospice care that meet the standard definition for hospice eligibility.

- For children with life-limiting conditions, but who have a life expectancy of greater than six (6) months, the primary care provider can submit the Physician Certification form for Partners In Care: Together For Kids (PIC:TFK) palliative care services. These services are for members with a potentially life limiting condition needing specialized palliative care services. Annual Physician Re-Certification will be required. This form, unique to the palliative care program, is in Appendix II.

- Upon receipt of the physician certification form, the primary care provider will submit a referral to the PIC:TFK provider for evaluation and admission into the program.

- The PIC:TKF provider will submit the initial Plan of Care with the identified service needs, frequency of service, the family's goals and the planned interventions. If medical necessity is met, the provider will receive an approval letter. The prior authorization number will be included in this letter and will be required on the claims submission form.

- An updated Plan of Care is required to be submitted quarterly from the palliative care provider to the utilization management department found on the child's member ID card.

3.0.8. Inpatient Hospitalization – including Mental Health and Skilled Nursing Care

- All non-emergent inpatient hospitalizations require prior authorization approval.

- Payment for psychiatric services is limited to general acute care hospitals. Services must be medically necessary.

- For inpatient mental health needs, CMS will reimburse providers for therapeutic group care during a hospitalization or mental health inpatient or crisis stabilization placement if the setting is not an Institution for Mental Diseases. CMS will also reimburse for services designed for children that are provided in a licensed residential group home setting.

- For children enrolled in the Behavioral Health Network (BNET) program, please contact the child's BNET liaison.

- Children being considered for skilled nursing care (nursing facility services) must have a staffing with the Children's Multidisciplinary Assessment Team (CMAT) to determine the most appropriate level of care needed, in consideration of medical needs and family request.

  See:
- Hospital Services Coverage and Limitations Handbook
  http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Hospital_Services_Handbook_December_2011.pdf

  Community and Behavior Heath Services Coverage and Limitations Handbook

http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Community_Behavioral_HealthHB.pdf

Nursing Facility Services Coverage and Limitations Handbook
http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_06_040701_Nursing_ver1_0.pdf

3.0.9. Out of Network and Out of State Providers

- Prior authorization is required for ALL non-emergency out of network and out of state services. Contact the utilization management department listed on the child's member ID card for any out of network or out of state service request.

3.0.10. Private Duty Nursing /Prescribed Pediatric Extended Care (PPEC)

- Requests for private duty nursing must be prior authorized and services may be reimbursable if determined medically necessary. CMS follows the Florida Medicaid Home Health Services Coverage and Limitations Handbook at this location http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Home_Health_Services_Handbook_March_2013.pdf

- Requests for PPEC services must be submitted, in writing, by the member's treating or attending physician or PPEC provider who receives a physician order. These requests must include all relevant supportive documentation as outlined below.
    - Prior Authorization form noting number of hours, frequency, duration, and level of skilled nursing services (home health aide, or nurse).
    - Physician order/recommendation must include PPEC is an appropriate place for care and specify the duration of PPEC service that does not exceed six (6) months. This order must be on the provider's office's letterhead or a prescription pad.
    - A Plan of Care from PPEC, including supporting documentation of the member's needs.

- During the approval period, if there is a change in the member's status or a change in hours necessary to care for the member, a new request for authorization must be submitted along with documentation of changes in the member's condition that necessitates the requested change.

- Approvals for PPEC services will not exceed six (6) months. Authorization requests must be resubmitted for any additional service period.

3.0.11. Therapy Services (PT, OT, Speech, and Respiratory)

- A request for therapy services (physical, occupational, speech/language, or respiratory therapy) is generally made in two phases: the initial assessment and the treatment plan.
    - The primary care or specialty physician will submit a prior authorization request for the initial assessment.

  - If approved, the therapist will conduct the assessment and develop a proposed treatment plan.
  - Once the treatment plan is approved and signed by the requesting provider it must be submitted for authorization of services.

- Services may be requested up to sixty (60) days in advance. The authorization period for these services may not exceed six months (180 days).

- Therapy services included on a child's Individualized Family Support Plan through the Early Steps program does not need a separate authorization request.

Notifications
3.0.12. Emergency Services

- Emergency services do not require prior authorization and are to be provided to all members in accordance with state and federal laws.

- If an emergency condition is determined to exist, the care, treatment, or surgery for a covered service by a physician which is necessary to relieve or eliminate the emergency medical condition within the service capability of a hospital will be a covered service.

- No later than the following business day after an emergency occurrence, the provider is required to notify the utilization management department listed on the child's member ID card of the member's demographics, facility name, and admitting diagnosis.

- Members shall not be sent to the Emergency Department during a primary care provider's normal office hours for the following
  - routine follow-up care,
  - follow-up for suture or staple removal, or
  - non-emergent care.

- The CMS Safety Net program is a limited service package and does not cover emergency services.

3.0.13. Admissions Through the Emergency Room – Hospitalizations

- Prior authorization is NOT required for emergent admissions. However, by the following business day, the hospital must notify the utilization management department listed on the member's ID card and provide member demographics, facility name, and admitting diagnosis.

- Any post-discharge services requiring authorization must be communicated through the normal authorization process described above.

- The CMS Safety Net program is a limited service package and does not cover inpatient hospital care services.

4.0.1. Appendix I - Special Exemption Form

Request for Children's Medical Services Coverage of Medically Necessary Special Services for a Child Under Age 19

Patient Name: _____ Date of Birth: _____ Medicaid ID: _____

This section must be completed by a physician, licensed clinician, or other provider

Requesting Provider Name: _____ National Provider ID: _____Telephone: _____ Fax: _____

Requesting Provider Name_____ National Provider ID: _____Telephone: _____ Fax: _____

Provider Type/Specialty: _____ This request is for a Product: ☐ Procedure: ☐ Service: ☐

CPT/HCPCS Code, *(if none, please describe)*: _____ Expected Frequency/Duration of Treatment: _____

_____

Is the request experimental or investigational? _____ Yes: ☐ No: ☐
(If yes, provide name and protocol)

_____

Is the request considered to be safe? _____ Yes: ☐ No: ☐
(If no, please explain why necessary)

_____

Is the request proved effective? _____ Yes: ☐ No: ☐
(If no, please explain why necessary)

_____

Is the request furnished in a manner primarily for the convenience of the provider, child, or parent/caregiver? Yes: ☐ No: ☐

(If yes, please explain why necessary) _____

_____

Please provide a description of how the requested procedure, product or service will correct or ameliorate the patient's defect, physical or mental illness, or condition. *(If more space is needed, please attach additional comments)*

_____

_____

Requester's Signature and Credentials: _____ License #: _____ Date: _____

Please attach <u>all related</u> medical records and evidence-based literature

This section must be completed by the Medical Consultant

Comments: Approved: ☐ Denied: ☐ Duration: _____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

This section must be completed by the Utilization Manager

Program Assigned: _____ Name/Title: _____ Date: _____

CPT/HCPCS Code: _____ Provider Type: _____ Duration: _____

Comments: _____

_____

4.0.2. Appendix II Palliative Care Program: Partners In Care: Together for Kids

Forms include:

- Partners in Care Electronic Form
- Physician Authorization/Re/Certification Form

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PARTNERS IN CARE (PIC) FAX REFERRAL

Section 1: Demographics:

Child's name: **SS#:** **DOB:** **Gender:** ☐ **M** ☐ **F**

School child attends: **Grade:** **ESE:** ☐ **Yes** ☐ **No**

Adult living with child: **Relationship:**

Adult living with child: **Relationship:**

Parent's marital status: **Legal guardian:**

Home address:

Home phone: **Work phone:** **Cell phone:**

Siblings living at home	DOB/Age	School attends

Other involved family members & relationship:

Section 2: Medical and Insurance Information

Primary Diagnosis: **Date of onset:**

Secondary Diagnosis: **Date of onset:**

Primary Care MD: **Phone:**

Address of Primary Care MD:

Other involved MDs, Specialty, and Phone #:

Medicaid Waiver/State Plan Services Form attached: ☐ **Yes** ☐ **N/A (child has Title XXI or Safety Net)**

Insurance: ☐ **Medicaid** ☐ **Title XXI** ☐ **Safety Net**

Current Trajectory of Illness: ☐**New (dx within last 3 mo, may/may not be in curative care)** ☐**Mid-Stage (at least 4 mo post-dx & on active treatment/intervention)** ☐**End Stage (4 mo or more post-dx & not responding to a normal course of treatment/interventions, future options limited)**

Suggested Services (Check all that apply): ☐ **Psychosocial Counseling** ☐ **Palliative Care Nurse Consult/Assessment** ☐**Personal Care** ☐ **Respite** ☐ **Pain & Symptom Management** ☐ **Spiritual Counseling** ☐ **Bereavement Counseling** ☐ **Volunteer Services**

CMS staff making referral: **Date faxed to PIC Provider:** **Phone:**

CMS care coordinator (if not same as referring staff): **Phone:**

Section 3: Disposition of Referral

PIC provider: **Phone:**

If more than 1 PIC provider available, choice made by family: ☐ **Yes** ☐ **N/A—only 1 PIC provider available**

Date referral completed: **Date faxed to PIC provider:**

Date & time referral received: **Patient enrolled:** ☐ **Yes—Date:** ☐ **No**

Contact Attempt dates: 1 **2** **3**

Reason if not enrolled:

PIC provider signature: **Date:** **Phone:**

PHYSICIAN AUTHORIZATION/ RE-CERTIFICATION

Instructions:

- **New patients**: This form must be signed by the child's Children's Medical Services Network primary care physician prior to discussing PIC with a parent/ caregiver.

- **PIC enrolled patients**: The Child's primary care physician must sign this form every twelve months (annually).

- **Please sign the form and fax back to Children's Medical Services (CMS) at _____.**

(Check one)

☐ Initial Certification

☐ Annual Re- Certification

CHILD'S NAME DOB
DIAGNOSIS:

I certify that , a CMSN enrolled child is diagnosed with a potentially life limiting condition.

_____
Physician's Signature

_____
Date

INSTRUCTIONS FOR THE PARTNERS IN CARE
PHYSICIAN AUTHORIZATION/ RE- CERTIFICATION

NOTE: The Partners in Care (PIC) Physician Authorization/Re-certification form contains confidential information and should only be used by authorized personnel as part of the medical and administrative record for the PIC participant. This form is designed to obtain written initial authorization and annual re-certification for services provided by the PIC provider. This form must be signed prior to inviting the family to participate in the PIC program and before Medicaid can be billed for services.

When the form is completed and signed by the primary care physician (PCP) or specialist they have authorized PIC services and have certified that the child has a potentially life limiting condition.

A completed and signed authorization/re-certification forms meets the following program Access Indicators and Performance Measures:

- Access Indicator 2
- Access Indicator 4
- Organizational and Administrative Structure

The CMS staff must enter the fax number prior to sending to the PCP or Specialist.

Copy of this form must be included in the CMS care coordinators file.